

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10893

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
e. COUNTY Wicomico		e. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hosp		d. STREET ADDRESS 705 E. Isabella St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN FRANKLIN ANDERSON, SR.		4. DATE OF DEATH Month Day Year Sept. 15 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman-&Farmer		10b. KIND OF BUSINESS OR INDUSTRY Bivalve, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John H. Anderson		14. MOTHER'S MAIDEN NAME Ella Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.# I		16. SOCIAL SECURITY NO. 420-0	
17. INFORMANT Mrs. Raymond Grimes (Daughter)		Address 705 E. Isabella St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. } DUE TO Coronary Occlusion Anterior sclerotic heart disease 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED Sept 16 / 1960	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ADDRESS 407 Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 19/60	
22c. NAME OF CEMETERY OR CREMATORY Bivalve Meth. Church Cem.		22d. LOCATION (City, town, or country) (State) Bivalve, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SEP 19 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

FOR STATE
HEALTH DEPT.

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CERTIFICATE OF DEATH

Reg. Dist. No. **10804****10820**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 516 Booth Street	
3. NAME OF DECEASED (Type or print) First Henrietta Middle Bowen Last Bowen				4. DATE OF DEATH Month Sept. Day 25 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 10 - 82	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Womestic		11. BIRTHPLACE (State or foreign country) Wicomico Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J.				14. MOTHER'S MAIDEN NAME Viola Hearne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ? INFORMANT Viola Hearne Address ?			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 hours ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 13 , 19 60 , to Sept. 25 , 19 60 that I last saw the deceased alive on Sept. 25 , 19 60 , and that death occurred at 1:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				ADDRESS (Street, city or town, state) Deer's Head Hospital DATE SIGNED 9/26/50			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-30-60		Green Acres		Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Burke M. West				24a. REC'D BY REGISTRAR DATE OCT 4 '60		24b. REGISTRAR'S SIGNATURE Chas. E. Hume	

CERTIFICATE OF DEATH

1942

County of _____ State of _____

On the _____ day of _____ 1942

at _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10805

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Locomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lloyd</u> First <u>Brittingham</u> Middle <u>Worcest</u> Last				4. DATE OF DEATH <u>September 14</u> Month <u>19</u> Day <u>60</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 16 1892</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Issac Brittingham</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Paterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>716-03-1489</u>		17. INFORMANT <u>Elsie Cropper</u> Address <u>Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTION</u> DUE TO <u>540.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>PULMONARY EMBOLUS</u> DUE TO (c) <u>PERFORATED PEPTIC ULCER</u>				INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>instant</u> <u>14 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>H. Gray Kears</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>15 Sept 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center, Salisbury, Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		23d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>	

CERTIFICATE OF DEATH

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10806

10822

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Salisbury, Md.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> c. LENGTH OF STAY IN 1b <u>31 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Hill Sanatorium</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>23X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Etchison</u> Last <u>Carey</u>				4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/1/1867</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>	
13. FATHER'S NAME <u>Lysander Etchison</u>				14. MOTHER'S MAIDEN NAME <u>Anna Correla Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. W. Royal, Ocean City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple myeloma</u> DUE TO <u>Coronary artery heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21/60</u> to <u>9/20, 1960</u> , that (I) (we) last saw the deceased alive on <u>9/20 19 60</u> and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>9/21/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE, M.D.</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Churchyard</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboys</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

may be retained by the
TO FUNERAL DIRECTOR: A
page 3 should be detached
the State Board of Health

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10555

10807

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Mardela		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLEN		First Middle Last CATLIN		4. DATE OF DEATH SEPT. 17th 19 60		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1878		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William A. Catlin			14. MOTHER'S MAIDEN NAME Margaret Phillips				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. Irvin G. Catlin-Son-Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Refractory Anemia DUE TO (b) Bone Marrow Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. lyng cause lost. (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Urinary Tract Infection with uremia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A		(County) 		(State) 	
21. I certify that (I) (this hospital) attended the deceased from October 1959 to Sept 17, 1960 that (I) (we) last saw the deceased alive on Sept 15, 1960 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas C. Hill				22b. DATE SIGNED Sept. 19 1960		22c. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill	
22d. ADDRESS Pine Bluff Rd. Salisbury, Maryland				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE Sept. 19 1960	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY Mardela Cem. (New Part) Mardela, Maryland		23d. LOCATION (City, town, or county) (State) 	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR SEP 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10857

10808

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb X Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1.		d. STREET ADDRESS Route # 1.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Edward Last Colona		4. DATE OF DEATH Month Sept. Day 9.th. Year 1960.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28.1874.
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 9	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS, OR INDUSTRY Builder.	11. BIRTHPLACE (State or foreign country) Worcester Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Colona		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Gilbert L. Jones (Daughter) Route #1 Salisbury, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-25-1959 to 9-9-1960 , that (I) (we) last saw the deceased alive on 9-6-1960 , and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Phillip A. Insley		22b. DATE SIGNED 9-10-60	
22c. PHYSICIAN'S NAME (Type) Dr. Phillip A. Insley		22d. ADDRESS E. XXXXX Main St. Salisbury, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF Sept. 11.60.	23c. NAME OF CEMETERY OR CREMATORY Shad Point Cem.	23d. LOCATION (City, town, or county) (State) Shad Point. Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.		25a. REC'D BY REGISTRAR SEP 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1

(M)

X

(I)

MEDICAL CERTIFICATION

1

BP

CERTIFICATE OF DEATH

1000

Place of Birth

Residence

Age

Sex

Marital Status

Occupation

Education

Date of Death

Time of Death

Place of Death

Cause of Death

Attending Physician

Death Certificate No. 1000

Signature of Physician

Death Certificate No. 1000

Signature of Registrar

Signature of Coroner

CERTIFICATE OF DEATH

10809

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1Yr.2Mos.3Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Route 1, Box 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hattie Loleta Cooper				4. DATE OF DEATH Month Day Year September 30 19 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Sept. 22, 1892		9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Williams				14. MOTHER'S MAIDEN NAME Sarah Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-7530		17. INFORMANT Hospital Records -- Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/28/ 1959 , to 9/30/ 1960 , that (I) (we) last saw the deceased alive on 9/30/ 1960 , and that death occurred at 6:PM , from the causes and on the date stated above.							
22a. SIGNATURE Lee L Lawry				ATTENDING PHYS. <input checked="" type="checkbox"/> 55 DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lee Lawry, M.D.				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/60		23c. NAME OF CEMETERY OR CREMATORY Grasonville, Md		23d. LOCATION (City, town, or county) (State) Grasonville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James B. Washell				25a. REC'D BY REGISTRAR DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Farris	

CERTIFICATE OF DEATH

10823

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF WITNESS: [illegible]

1

[Faint, mostly illegible text at the bottom of the page, possibly a continuation of the certificate or a separate document.]

1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10858
CERTIFICATE OF DEATH
10810

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mardela Springs				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mardela Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Florence Last Dashiell				4. DATE OF DEATH Month September Day 28 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Issac Waller				14. MOTHER'S MAIDEN NAME Olevia Hull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-07-7173		17. INFORMANT John W. Dashiell Address RFD Mardela S prings	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 544.2 DUE TO acute indigestion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) over eating - after hard days (c) work PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 8P. M, from the causes and on the date stated above.							
22a. SIGNATURE Fred C. Quinn				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 29 60	
22c. PHYSICIAN'S NAME (Type) Fred C. Quinn				22d. ADDRESS Mardela Springs, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 2, 1960		23c. NAME OF CEMETERY OR CREMATORY Green Acres Cemetery		23d. LOCATION (City, town, or county) (State) Wicomico County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son				25a. REC'D BY REGISTRAR Federalsburg DATE OCT 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

10858

CERTIFICATE OF DEATH

10858

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10824
10811
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General</u>				d. STREET ADDRESS <u>106 New York Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>LEE</u> Last <u>Disharoon</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 26, 1886</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bldg. and Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fruitland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Sidney Disharoon</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Cora E. Disharoon (Wife)</u> Address <u>106 New York Ave. Salisbury, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
20f. (City or town) <u>N/A</u> (County) <u>N/A</u> (State) <u>N/A</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>9/18/60</u> to <u>9/21/60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/21/60</u> 19 <u>60</u> , and that death occurred at <u>5 A</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>L. R. Gramme</u>				22b. DATE SIGNED <u>Sept. 23/1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramme</u>				22d. ADDRESS <u>S. Divison St. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 23, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>				(State) <u></u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1981

1981

CERTIFICATE OF DEATH

1981

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of registrar: [illegible]
9. Signature of medical officer: [illegible]
10. Signature of informant: [illegible]

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10825

10812

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 168 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS RFD # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ada Middle Gottwals Last Gottwals				4. DATE OF DEATH Month September Day 1 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1890	9. AGE (In years lost birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Hutson				14. MOTHER'S MAIDEN NAME Mary Elizabeth Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Christial Gottwals Denton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Volvulus of colon							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17 19 60 to Sept. 1 19 60 , that (I) (we) last saw the deceased alive on Sept. 1 19 60 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.				22b. DATE SIGNED 9/1/60		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.	
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-60		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulois Greensboro, Md.				25a. REC'D BY REGISTRAR DATE SEP 6 '60		25b. REGISTRAR'S SIGNATURE Christal L. Thomas	

MEDICAL CERTIFICATION

2580

CERTIFICATE OF DEATH

Reg. Dist. No.

10813

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 3 wks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hosp		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 705 E. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle — Last HAGAN, Sr		4. DATE OF DEATH Month 9 Day 18 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1873
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel		10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew A. Hagan	
14. MOTHER'S MAIDEN NAME Anne Mary Olson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-10-9476		INFORMANT Address Louella C. Hagan, same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary occlusion DUE TO (b) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8:27 , 19 60 to 9:18 , 19 60 that I last saw the deceased alive on 9:18 , 19 60 , and that death occurred at 3:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center Salisbury Md. DATE SIGNED 9-19-60 ACTUAL SIGNATURE H. A. Briele M.D. PHYSICIAN'S NAME (Type) H. A. Briele			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/20/1960	22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park	22d. LOCATION (City, town, or county) (State) Salisbury Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.		ADDRESS Salisbury	24a. REC'D BY REGISTRAR DATE SEP 21 '60
24b. REGISTRAR'S SIGNATURE William S. Hume			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100-30

CERTIFICATE OF DEATH

100-30

Name of Deceased		Date of Death	
John Doe		10-10-1970	
Place of Birth		Place of Death	
New York, N.Y.		New York, N.Y.	
Age at Death		Sex	
45		Male	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Atherosclerosis	
Contributing Cause		Hypertension	
Doctor's Signature		Medical Examiner's Signature	
[Signature]		[Signature]	
Date of Certificate		Place of Issuance	
10-10-1970		New York, N.Y.	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10814

10827

Item 2 Film 0271 9-16-60

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23 1/2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		d. STREET ADDRESS Rt. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) THOMAS		First		Middle		Last HOLLAND		4. DATE OF DEATH September 2, 1960		Month		Day		Year					
5. SEX male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880		9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months		Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Crisie Holland		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Linford Tunnell - Seeberry		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNDERLIEING CAUSE LOST		INTERVAL BETWEEN ONSET AND DEATH 2 weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIA, HEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/1 19 60 , to 9/2 19 60 , that (I) (we) last saw the deceased alive on 9/2 19 60 , and that death occurred at 1:03 PM, from the causes and on the date stated above.		22a. SIGNATURE John M. Bloxam III		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOHN M. BLOXAM III		22d. ADDRESS MEDICAL CENTER SALISBURY, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) 1 burial		23b. DATE THEREOF 10/8/60		23c. NAME OF CEMETERY OR CREMATORY Sarah Duke		23d. LOCATION (City, town, or county) (State) Bishop Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines													

CERTIFICATE OF DEATH

100-37

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1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10859 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10815

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 205 Pine St.		d. STREET ADDRESS 205 Pine St.	
3. NAME OF DECEASED (Type or print) WILLIAM CHARLES HUTCHISON		4. DATE OF DEATH Month SEPT. Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Seaford Dupont Plant		11. BIRTHPLACE (State or foreign country) Delmar, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Oscar Hutchison	
14. MOTHER'S MAIDEN NAME Flora (Unk)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 221-09-8819		17. INFORMANT Mrs. Mary L. Hutchison (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Handed hit with on ground during Hurricane	
20c. TIME OF INJURY Month, Day, Year 12:30 a.m. 9/12 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Delmar (Wicomico) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer-407 Camden Ave.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14/60	
22c. NAME OF CEMETERY OR CREMATORY M.E. Methodist Cemetery		22d. LOCATION (City, town, or country) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SEP 15 '60	
ADDRESS SALISBURY, MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10860

CERTIFICATE OF DEATH

Reg. Dist. No.

10816

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b 5 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NINA Middle WEBB Last INSLEY				4. DATE OF DEATH Month 9 Day 7 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80		11. IF UNDER 24 HRS. Days 80 Hours 80 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W.T. Webb				14. MOTHER'S MAIDEN NAME Anna Virginia Conway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Address Mr. Alan Insley, Millington N,J,							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Sublethal Virus DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) ? (c) ?							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 60 , to Sept 7 , 19 60 , that I lost saw the deceased alive on Sept 6 , 19 60 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.S. Kuhlman		M.D. Sharptown, Maryland		DATE SIGNED 9-7-1960			
PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman		Sharptown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-1960		22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co. Salisbury, Maryland				24. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

10-1-19

CORNER OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
15M 9/59

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10828
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10817

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		d. STREET ADDRESS <u>213 N. Baltimore 23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES TILGHMAN Jackson</u>		4. DATE OF DEATH Month Day Year <u>September 9- 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1867</u>
9. AGE (In years last birthday) yrs. <u>93</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Capt. Lambert W. Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Bradley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ralph Dennis, Ocean City, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/2</u> 19 <u>60</u> to <u>9/9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>60</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>9-9-1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		22d. ADDRESS <u>Pine Bluff Rd., Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-13-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

CERTIFICATE OF DEATH

1902

County of _____ State of _____

Deceased _____

Age _____

July 22, 1902

Married _____

Genl. James W. Jackson

Res. Raleigh, N.C.

David A. Silvers

Rich. M. H. H. H.

Funeral _____

At _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10818

10829

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL or outside corporate limits) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Fooks Street.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Durand Jenkins		4. DATE OF DEATH Sept. 10. Month 10. Day 19 Year 60.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1878.
9. AGE (In years, lost birth day) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last year of working life, even if retired) Retired Worker		10b. KIND OF BUSINESS OR INDUSTRY At Pen. Gen. Hospt.	
11. BIRTHPLACE (State or foreign country) Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Jenkins		14. MOTHER'S MAIDEN NAME Emma Wainwright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lucy M. Jenkins (Wife)		18. ADDRESS OF INFORMANT 110.fooks St. Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH less than hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Coronary Artery Heart Disease; Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19 58 to Sept. 12, 19 60 that (I) (we) last saw the deceased alive on Sept. 9, 19 60 and that death occurred at 6:45 p.m. from the causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED Sept 12 1960	
22c. PHYSICIAN'S NAME (Type) Dr. David A. Gilmore		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 13, 1960. Parsons Cemetery.		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Salisbury, Maryland.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland,		25a. REC'D BY REGISTRAR SEP 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

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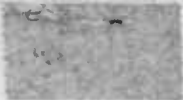
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>10 HOURS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u>		d. STREET ADDRESS <u>R.F.D. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SALISBURY PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELTON MARTIN JONES</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 17 1960</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1, 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY JONES</u>				14. MOTHER'S MAIDEN NAME <u>ELLA WATSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-34-9239</u>		17. INFORMANT <u>WILLIAM H. JONES, Pocomoke City, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-17-60</u> to <u>9-17-60</u> , that (I) (we) lost the deceased on <u>9-17-60</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. R. Ellis Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. R. ELLIS JR</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-20-60</u>		23c. NAME OF CEMETERY <u>REMSON METHODIST</u>		23d. LOCATION (City, town, or county) (State) <u>RURAL - Pocomoke City, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>				ADDRESS <u>Pocomoke City, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10831

10820

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Cherry St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SARAH PRISCILLA JONES				4. DATE OF DEATH Month Day Year SEPT. 13th 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1877	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME James H. Martin				14. MOTHER'S MAIDEN NAME Mary Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Harry J. Wheatley (Daughter)				Address 104 Cherry St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Asterio sclerosis + Chronic infection DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A				20g. (County) N/A		20h. (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Jan 8, 1958 to Sept. 13, 1960 , that (II) (we) last saw the deceased alive on 9/13 1960 , and that death occurred at 8:20 P M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. W. B. Smith				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE Sept. 14 / 1960	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith				22d. ADDRESS Medical Center Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1960		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR SEP 16 '60	
				25b. REGISTRAR'S SIGNATURE Carlton S. Kline			



CERTIFICATE

100-11

100-11



100-11



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
10832

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10821

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DEL.</u> b. COUNTY <u>SUSSEX</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SELBYVILLE</u>			
d. NAME OF HOSPITAL (If met in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>46X-5</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE W. Lathbury</u>				4. DATE OF DEATH Month Day Year <u>September 19 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/10/1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>JOHN WAINWRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>JANE WAINWRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>222-14-1053</u>		17. INFORMANT Address <u>Everett Lathbury Selbyville Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/17/1960</u> to <u>9/19/1960</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE <u>9/19/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ALFRED LYNCH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SELBYVILLE DE.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson Pocomoke md.</u>				25a. REC'D BY REGISTRAR <u>SEP 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10822

10861

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
c. LENGTH OF STAY IN 1b 25 yrs				d. STREET ADDRESS / 408 Maryland Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Maryland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Lewis Last Lewis				4. DATE OF DEATH Month Sept. Day 30th Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1875		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christin Wolfe				14. MOTHER'S MAIDEN NAME Mariah Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mabel Lewis, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis bilateral far advanced. 002X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to Sept 30 , 19 60 , that (I) (we) last saw the deceased alive on Sept 29 , 19 60 , and that death occurred at 120 M, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Sohler M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. V. Sohler				22d. ADDRESS Delmar, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-6-		23c. NAME OF CEMETERY OR CREMATORY First Methodist		23d. LOCATION (City, town, or county) (State) Delmar, Del.	
24. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del.				25a. REC'D BY REGISTRAR DATE OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

M

1

MEDICAL CERTIFICATION



1

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89

10823

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1506 Rose Drive				d. STREET ADDRESS 1506 Rose Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL BENJAMIN MARSHALL				4. DATE OF DEATH Month SEPT. Day 4th Year 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1905			
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 1 Days 22 Hours Min. 		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk - Shoreland Freezer				10b. KIND OF BUSINESS OR INDUSTRY R.D.# Salisbury, Md.		11. BIRTHPLACE (State or foreign country) U S A			
12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Samuel Benjamin Marshall				14. MOTHER'S MAIDEN NAME Irene Washburn					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Hilda Marshall (Wife) Rose Drive (1506) Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Carcinoma of lung 163X DUE TO = widespread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Hour o. m. p. m. N/A Month Day 19 Year 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from July 25, 1960 to September 4, 1960 , that (I) (we) last saw the deceased alive on September 1, 1960 , and that death occurred at 2:28 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Robert T. Adkins				22b. DATE SIGNED Sept. 6 / 1960					
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins				22d. ADDRESS Fruitland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR SEP 9 '60		25b. REGISTRAR'S SIGNATURE Wm. S. Evans	

— MAXIMIZING STATE REVENUE AND MINIMIZING THE BURDEN OF DEATH —

THE STATE
OF NEW YORK



1903

Wicks
Sullivan
Meyers
Sullivan

Continental General Hospital

Josephine M. Sullivan, Jr.

9-2-03

Crushed chest

Sullivan

Josephine M. Sullivan, Jr.

9-2-03

9-2-03

Josephine M. Sullivan, Jr.

Josephine M. Sullivan, Jr.

9-2-03

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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Page 4

10835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10825

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER'S HEAD STATE HOSPITAL		d. STREET ADDRESS 221 West End Ave.	
3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last MUNSON		4. DATE OF DEATH Month 9 Day 13 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newton, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Years Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 7-28 19 60 to 9-13 19 60 that (I) (we) last saw the deceased alive on 9-13 19 60 and that death occurred at 9:50 AM from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 9-13-60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 15, 1960	
23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		23d. LOCATION (City, town, or county) (State) Church Creek, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth L. Shores		25a. REC'D BY REGISTRAR DATE SEP 20 '60	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10836

10826

1. PLACE OF DEATH o. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>14X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>R.F.D. #3, Quaker Neck</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAGGIE Murray</u>		4. DATE OF DEATH Month Day Year <u>9 6 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1894</u>
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Houston</u>		14. MOTHER'S MAIDEN NAME <u>Cora Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Marian Murray</u>		Address <u>Chestertown, Md.</u> <u>sister</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with advanced metastases</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/17, 1960</u> to <u>9/6, 1960</u> , that (I) (we) lost saw the deceased alive on <u>9/6, 1960</u> , and that death occurred at <u>6:15 p.m.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Juerman</u>		22b. DATE SIGNED <u>9-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. Juerman, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital</u> <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/10/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Janes Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin C. Cobb</u>		ADDRESS <u>Chestertown, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10837

CERTIFICATE OF DEATH

Reg. Dist. No.

10827

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant Care Nursing Home		d. STREET ADDRESS 17X-2	
3. NAME OF DECEASED (Type or print) First Ada Middle Norwood Last Chance		4. DATE OF DEATH Month September Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1864
9. AGE (In years lost birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Wesley Miles		14. MOTHER'S MAIDEN NAME Ellen Miles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mrs. Norman Taylor, Chance, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO 450.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure DUE TO generalized arteriosclerosis (c) chronic dehydration	
19. INTERVAL BETWEEN ONSET AND DEATH 15 min -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 60 , to September , 19 60 that I last saw the deceased alive on 16 September , 19 60 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Adkins		ADDRESS (Street, city or town, state) Fruitland, Maryland	
DATE SIGNED 26 Sept 60		PHYSICIAN'S NAME (Type) James L. Adams	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/60	
22c. NAME OF CEMETERY OR CREMATORY Demascus Methodist		22d. LOCATION (City, town, or county) (State) Demascus, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Adams		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Adams			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10887

CERTIFICATE OF D

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10862
CERTIFICATE OF DEATH

10828

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Claude S. Nutter</u>				4. DATE OF DEATH <u>9-3-60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster tonger</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Hesriah Nutter</u>				14. MOTHER'S MAIDEN NAME <u>Leah Jane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-12-6994</u>		17. INFORMANT <u>Rose Barclay</u> Address <u>Nanticoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic Heart Disease</u> (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>14 Jan 1949</u> to <u>4 Sept 1960</u> , that (I) (we) last saw the deceased alive on <u>4 Sept 1960</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Saunders</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				22d. ADDRESS <u>NANTICOKE Md.</u>			
23a. BURIAL, CREMATION, RECOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-7-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Messier Bivolar, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

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CERTIFICATE OF DEATH

1980

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State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that
the within and foregoing is a true and correct copy of the original record of the death of
[Name] [Age] [Sex] [Race] [Color] [Religion] [Marital Status] [Occupation] [Cause of Death] [Date of Death] [Place of Death] [Time of Death] [Signature of Medical Officer of Health] [Date of Certification] [Place of Certification]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10829

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MARDELA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. ROUTE 50</u>		d. STREET ADDRESS <u>2125 BRANDYWINE ST.</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE LEE QUERTON</u>		4. DATE OF DEATH <u>Sept 2 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1903</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Army MAJOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. ARMY</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SPROLES</u>		14. MOTHER'S MAIDEN NAME <u>CAMIEL RODGERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Dr. L.A. RAPEE, Washington, D.C.</u>	
17. INFORMANT <u>Dr. L.A. RAPEE, Washington, D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head Injuries -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>825X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:20 Hour 9 2 1960</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 50</u>	20f. (City or town) <u>Wicomico - Md</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-9-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORREST PARK CEMETERY</u>		22d. LOCATION (City, town, or county) <u>HOUSTON TEXAS</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Wallace Salisbury Ind</u>		24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10838

10830

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 Mo. 5 Da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>5 Delaware Avenue</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Mildred Palmer</u>				4. DATE OF DEATH Month Day Year <u>September 23 19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1931</u>	9. AGE (In years lost birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clarence Hutt</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>10</u>		17. INFORMANT Address <u>Hospital Records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of Cervix uteri w/metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>3 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pylonephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/19/</u> 19 <u>60</u> , to <u>9/23/</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/23/</u> 19 <u>60</u> , and that death occurred at <u>5P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-20-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks & Co.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10690

CERTIFICATE OF DEATH

10690

Blank form with horizontal lines for text entry.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10839
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10831

CERTIFICATE OF DEATH

Item 2 151M0272 10-3-60 et

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>505 Lake Street</u> <u>Peninsula General Hospital</u>	
3. NAME OF DECEASED (Type or print) First <u>Harrison</u> Middle <u>B.</u> Last <u>PARSONS</u>		4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, 1888</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sub. Station Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Parsons</u>	
14. MOTHER'S MAIDEN NAME <u>Charolette Dashiell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hattie Parsons</u> Address <u>Lake St. Salisbury Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO <u> </u> (c) <u>Cardiac Hypertrophy + Bronchial Inflammation</u> DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 19 <u>60</u> to <u>9/20</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>60</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Smith</u>		22b. DATE SIGNED <u>9/21/60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/23/ 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR <u>SEP 28 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Clinton F. Stewart</u>		25c. DATE <u>SEP 28 '60</u>	

10831
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
DATE: [Illegible]
TO: [Illegible]
FROM: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text.]

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
10840
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10832

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Jersey Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hattie Middle Pearson Last Pearson		4. DATE OF DEATH Month Sept. Day 12 Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Parker		14. MOTHER'S MAIDEN NAME Josephine Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Josephine White	
17. INFORMANT Josephine White		Address Jersey Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left breast with generalized metastases. DUE TO metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1702 (c) 1702 DUE TO 1702 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 26 1960 , to Sept. 12 1960 , that (I) (we) last saw the deceased alive on Sept. 12 1960 , and that death occurred at 8:15 A.M. M, from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 9-13-60	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/17/1960	
23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City, town, or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		25. REC'D BY REGISTRAR Salisbury Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SEP 20 '60	

112841

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10833

10841

See: Birth Cert. at

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Larry James Peek</u>		4. DATE OF DEATH <u>September 6 - 1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12:55 A.M. 9-5-60</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>P.G. Hospt. Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lee Peek</u>		14. MOTHER'S MAIDEN NAME <u>Phylliss Lou Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Lee Peek (Father)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyaline Membrane Disease</u> DUE TO (c) <u>Prematurity</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> 19 <u>60</u> , to <u>9/6</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>60</u> , and that death occurred at <u>8AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Morgan</u>		22b. DATE SIGNED <u>9/6/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>		22d. ADDRESS <u>Medical Center Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u>		ADDRESS <u>Salisbury, Maryland.</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Wm S. Thomas</u>	

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mandela Springs</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Shade Nursing Home</u>		d. STREET ADDRESS <u>20X-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel BOONE POPE</u>		4. DATE OF DEATH Month Day Year <u>Sept. 26, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Charles Boone</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Alverda Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <u>Monahan L. Thompson</u>		17. INFORMANT <u>Monahan L. Thompson</u> Address <u>Oxford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arterio Sclerotic Heart</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Sept 26, 1960</u> that I last saw the deceased alive on <u>Sept 26, 1960</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. S. Kuhlman</u> M.D.		ADDRESS (Street, city or town, state) <u>Sharpton Md</u> DATE SIGNED <u>9/27/60</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 29, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oxford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF TITLE

1896

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1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10865
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10835

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 East Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Ellen Last Poulson		4. DATE OF DEATH Month Sept. Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Laurel, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Greensbury White		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Doris Green, Delmar, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arteriosclerotic heart disease with failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; acute anemia INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 15 19 60 , to 19 19 60 , that (I) (we) last saw the deceased alive on Sept 15 19 60 , and that death occurred at 10:00 P.M., from the causes and on the date stated above.			
22a. SIGNATURE E. M. Larmore		22b. DATE SIGNED 9/16/60	
22c. PHYSICIAN'S NAME (Type) E. M. LARMORE		22d. ADDRESS DELMAR DEL.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-18-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City, town, or county) (State) Delmar, Del.	
24. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del.		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

10-65



10



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[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "MAY 1965" and "DEATH" are visible.]

1
FOR STATE HEALTH DEPT. **M**
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10842

Item 2 Film 272 10-10-60 et

10836

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General			d. STREET ADDRESS Route # 3		
3. NAME OF DECEASED (Type or print) George W Purnell			4. DATE OF DEATH 9-20-60 19		
5. SEX M			6. COLOR OR RACE A A		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7-25-76		
9. AGE (In years last birthday) 84 yrs.			10. IF UNDER 1 YEAR Months Days		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Henry Purnell			14. MOTHER'S MAIDEN NAME Emma Purnell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Derrickson Purnell, Baltimore, Md.			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 9-23-60		
22c. NAME OF CEMETERY OR CREMATORY Fooks Cem			22d. LOCATION (City, town, or country) (State) Nr Berlin, Md.		
23. FUNERAL DIRECTOR Thornton B. Jolley, Salisbury, Md			24a. REC'D BY REGISTRAR SEP 29 '60		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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FOR STATE HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10837

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 706 Howard St		d. STREET ADDRESS 706 Howard St	
3. NAME OF DECEASED (Type or print) JOYCE RAY ROBINSON		4. DATE OF DEATH Month SEPT. Day 20th Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED Baby	8. DATE OF BIRTH June 5, 1960
9. AGE (in years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 3 Days 15	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Ray Bennett Robinson	
14. MOTHER'S MAIDEN NAME Margaret Ellen Shockley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Ray B. Robinson (Father) Address 706 Howard St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 924.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Face down in basement on soft pillow & rubber sheet	
20c. TIME OF INJURY Month, Day, Year 120 Hour a.m. 9-20-60 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. City or town (County) (State) Salisbury Wicomico Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR SEP 26 '60		24b. REGISTRAR'S SIGNATURE Orlino S. Kraus	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10855

10838

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. LENGTH OF STAY IN 1b X Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) Main Street.		e. IS RESIDENCE ON A FARM? X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha First Lillian Middle Ruark Last		4. DATE OF DEATH Month Sept. Day 6. Year 60.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1889.
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Owens		14. MOTHER'S MAIDEN NAME Elizabeth Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Robert Pruitt (Daughter) R.D. Salisbury, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Thrombia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) Assoc. Fractured hip			INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs. 2 mks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1958 , to 9/6, 1960 , that (I) (we) last saw the deceased alive on 9/4, 1960 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. B. Smith		22b. DATE SIGNED 9/8/60	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 9. 60.	23c. NAME OF CEMETERY OR CREMATORY Red Men Cem.	23d. LOCATION (City, town, or county) (State) Dagsboro, Delaware.
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		25a. REC'D BY REGISTRAR SEP 13 '60	
ADDRESS Salisbury, Maryland,		25b. REGISTRAR'S SIGNATURE Arthur L. House	

WESTERN STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10839

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Item 7 Film 272 10-3-60 et

1. PLACE OF DEATH a. COUNTY WICOMICO		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2038 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		d. STREET ADDRESS 4708 Indian Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jessie Middle Emma Last Sheehan		4. DATE OF DEATH Month 9 Day 23 Year 1960		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (Separated) WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-94		9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 23 Hours 19 Min. 60					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Willard Boyle		14. MOTHER'S MAIDEN NAME Emma Crooley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 004-22-9462		17. INFORMANT Amelia C. Boyle, 4708 Indian Lane, College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subtotal occlusion of left coronary artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus and Adenocarcinoma of colon.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/24 19 55 to 9/23 19 60 , that (I) (we) last saw the deceased alive on 9/23 19 60 , and that death occurred at M , from the causes and on the date stated above.		22a. SIGNATURE L. V. Maldve		22b. ADDRESS Deer's Head State Hospital, Salisbury, Md.		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		22e. REC'D BY REGISTRAR SEP 28 '60		22f. REGISTRAR'S SIGNATURE Arthur L. Kraus		22g. DATE SEP 28 '60		22h. SIGNATURE Arthur L. Kraus		22i. DATE SEP 28 '60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		24a. ADDRESS Riverdale, Maryland		24b. DATE SEP 28 '60		24c. SIGNATURE Arthur L. Kraus		24d. DATE SEP 28 '60		24e. SIGNATURE Arthur L. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10845
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10840

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 333 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HYDIE Middle SMITH Last SMITH		4. DATE OF DEATH Month 9 Day 18 Year 19 60	
5. SEX male	6. COLOR OR RACE c ol.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-96
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Brown		14. MOTHER'S MAIDEN NAME Lydia Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-09-1122	
17. INFORMANT Calvert St.		Mrs. Elnora Murray Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Artery Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-21 1959 to 9-18 1960 , that (I) (we) last saw the deceased alive on 9-18 1960 , and that death occurred at 6:00 a.m. M, from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 9-19-60	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/60	
23c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Bennett Webb		25a. REC'D BY REGISTRAR SEP 21 '60	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Lewis	

108-12

Received by Mr. Chesterman, Jr.
9/21/60

W. J. Chesterman, Jr.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>State & School St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARLEY ALPHONSO SPEARE</u>				4. DATE OF DEATH Month Day Year <u>Sept. 30, 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>commercial fisherman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph W. Speare</u>				14. MOTHER'S MAIDEN NAME <u>Alpha A. McWilliams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-4009</u>		17. INFORMANT <u>Mr. Joseph W. Speare</u>		Address <u>Sharptown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>H20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 30, 1959</u> , to <u>Sept 30, 1960</u> , that I last saw the deceased alive on <u>Sept 30, 1960</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. S. Kuhlman</u> M.D.				ADDRESS (Street, city or town, state) <u>Sharptown, Md.</u>			
DATE SIGNED <u>10/1/60</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Howard S. Kuhlman</u>				<u>Sharptown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Taylor's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>				ADDRESS <u>Sharptown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kane</u>			

10866

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. NAME OF SPOUSE Mary H. Harris		10. PLACE OF MARRIAGE Baltimore, Md.	
11. CAUSE OF DEATH Heart Disease		12. ICD-10 CODE I25.9		13. DATE OF DEATH 1955		14. PLACE OF DEATH Home		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris		19. SIGNATURE OF WITNESS J. H. Harris		20. SIGNATURE OF WITNESS J. H. Harris	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10842

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Howard Taylor</u>		4. DATE OF DEATH <u>September 6 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7. 1902.</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Lank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Grace Taylor (Wife)</u>		Address <u>502 Washington, St. Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>60</u> to <u>9/6/60</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/6/60</u> , 19 <u>60</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>F.R. Gramse</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. F.R. Gramse</u>		22d. ADDRESS <u>S. Div. St. Salisbury, Maryland.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 9. 60.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cem,</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Salisbury, Maryland.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>			

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10867

CERTIFICATE OF DEATH

10843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural Mardela</u>			d. STREET ADDRESS <u>Rural Mardela</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Ellen</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1874</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>George Washington Gillis</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Horseman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Harry Banks RFD. Mardela, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with failure.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12</u> , 19 <u>54</u> , to <u>9/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/15</u> , 19 <u>60</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>106 Green St</u> <u>9/6/60</u>					
ACTUAL SIGNATURE <u>Arthur S. Larmore</u>		M.D. <u>E. M. LARMORE</u>			
PHYSICIAN'S NAME (Type) <u>E. M. LARMORE</u>		<u>Robman, Del</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Firemens</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>		ADDRESS <u>Sharptown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Larmore</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. HARRIS		AGE 65		SEX Male		RACE White		DATE OF DEATH April 10, 1941	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Harford		STATE Md.		ZIP CODE 21201	
OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		RELIGION Methodist		BIRTH DATE April 10, 1876	
CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		INTERMEDIATE CAUSE Arteriosclerosis		FUNDAMENTAL CAUSE None	
DATE OF EXAMINATION April 10, 1941		PLACE OF EXAMINATION Home		BY Dr. J. H. Smith		MANNER OF EXAMINATION Autopsy		RESULTS As above	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED John J. Harris		SIGNATURE OF WITNESS John J. Harris		SIGNATURE OF WITNESS John J. Harris		SIGNATURE OF WITNESS John J. Harris	
DATE OF SIGNATURE April 10, 1941		DATE OF SIGNATURE April 10, 1941		DATE OF SIGNATURE April 10, 1941		DATE OF SIGNATURE April 10, 1941		DATE OF SIGNATURE April 10, 1941	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF HARFORD, MARYLAND.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10844

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Neal Clinton Taylor		4. DATE OF DEATH Month Sept. Day 9. Year 60.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1897.
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 8 Days 3 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Plant	
11. BIRTHPLACE (State or foreign country) Accomac Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George H. Taylor		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary L. Taylor (Wife) Salisbury, Md. Route L.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis Unburnt DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH less than hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1959 to Sept. 9, 1960 , that (I) (we) last saw the deceased alive on Sept. 8, 1960 and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED Sept. 12 - 1960	
22c. PHYSICIAN'S NAME (Type) Dr. David A. Gilmore		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 12, 1960.	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park.		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.		25a. REC'D BY REGISTRAR DATE SEP 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hand			

1904

MAINTENANCE DEPARTMENT OF HEALTH
CITY OF CHICAGO
CERTIFICATE OF DEATH

1904

Name of deceased: [illegible] Age: [illegible] Sex: [illegible]

Residence: [illegible] Date of death: [illegible]

Place of death: [illegible] Cause of death: [illegible]

Signature of physician: [illegible]

Signature of coroner: [illegible]

Signature of registrar: [illegible]

Signature of [illegible]: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Mt Hermon</u>		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsburg (Rural)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt.D.# 1 Mt Hermon Rd</u>				d. STREET ADDRESS <u>Rt.D.# 1 Mt Hermon Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Gilghman</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11, 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Parsonsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Asbury Perdue</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. E. Lester Shockley (Daughter)</u> Address <u>R.D.# 1 Mt Hermon Rd Parsonsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>N/A</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) <u>N/A</u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick McCallough</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Kendrick McCallough</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsonsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parsonsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE SEP 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>		DATE SIGNED <u>Sept. 25, 19 60</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Philip A. Insley
Dr. Philip A. Insley - Main St. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 19/60	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or country) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR SEP 20 '60	
ADDRESS SALISBURY, MARYLAND		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial puenmonitis DUE TO (b) 763.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen Gen Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS R.D. # 5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LORIE MARIE TOADVINE		4. DATE OF DEATH Month Day Year SEPT. 17 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Baby	8. DATE OF BIRTH Sept. 12, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 0 Months 8 Days 0 Hours 0 Min.
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Theodore Albert Toadvine		14. MOTHER'S MAIDEN NAME Charlotte Laird	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Theodore A. Toadvine (Father)		Address R.D. # 5 Salisbury, Maryland	

10847 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10846

VS. A15ME
SM 7/59

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director, who should be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10847											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D.C. b. COUNTY ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						c. LENGTH OF STAY IN 1b Washington 47X-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						d. STREET ADDRESS 1503 Crittenden St. N.W.					
3. NAME OF DECEASED (Type or print) Fannie L. Voronoff						4. DATE OF DEATH Month 9 Day 11 Year 60					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-88		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? USA	
3. FATHER'S NAME Joseph B. Spund						14. MOTHER'S MAIDEN NAME Zelda —					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Address Jacob Voronoff 1503 Crittenden St., NW					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Ruptured spleen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) 854X										INTERVAL BETWEEN ONSET AND DEATH 5 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Auricular fibrillation. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Slipped in boat in Ocean City and struck chest.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:40 P.M. 9-6-60				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> X Boat.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ocean City Worcester Md.			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9-11-60			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) (State) 407 Camden Ave. Salisbury, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-13-60		22c. NAME OF CEMETERY OR CREMATORY Oheg-Sholom-Talmud-Torah Cem. Hillside, Maryland				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR Bernard Danzansky & Sons						ADDRESS 3501 14th St., NW		24a. REC'D BY REGISTRAR SEP 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A16 (4)
15M/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10849
CERTIFICATE OF DEATH

10848

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MELVIN PAUL WALKER				4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1:15 AM Sept. 15, 1960	
9. AGE (In years lost birthday) 0 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury (Hospital) Md.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Melvin Lee Walker		14. MOTHER'S MAIDEN NAME Pauline Mae Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Melvin Lee Walker (Father) R.D. # 3 (Ocean City Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation - Acute 773X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyaline Membrane Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 20 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Hour o. m. p. m. N/A 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		
20f. (City or town) N/A			20g. (County) N/A		20h. (State) N/A		
21. I certify that (I) (this hospital) attended the deceased from 9/15 19 60 , to 9/15 19 60 , that (I) (we) last saw the deceased alive on 9/15 19 60 , and that death occurred at 9:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE William C. Morgan				22b. DATE SIGNED Sept. 16 / 1960			
22c. PHYSICIAN'S NAME (Type) Dr. William Morgan				22d. ADDRESS Medical Center-Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Howard							

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10850

10849

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Phillips St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CALVIN</u> Middle <u>LEWIS</u> Last <u>WELLS</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1895</u>		9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-laborer-Construction Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New Church, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Zadock Wells</u>				14. MOTHER'S MAIDEN NAME <u>Viola Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>		17. INFORMANT <u>Mrs. Elizabeth Wells (Wife)</u> Address <u>Phillips St Hebron, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>3 yrs</u> <u>14 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 59</u> to <u>Sept 12, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 4, 1960</u> and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>B. Frank Giganti</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 13, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. B. Frank Giganti</u>				22d. ADDRESS <u>Woodland Rd. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOILWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 15 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10850

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>412 Dover St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WAKEMAN WINDSOR Whayland</u>				4. DATE OF DEATH Month Day Year <u>September 29 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1903</u>	9. AGE (In years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>R.D.# Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Theodore Wesley Whayland</u>				14. MOTHER'S MAIDEN NAME <u>Martha Letitia Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mr. Charles T. Whayland (Son) Hebron, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Years?</u> <u>yes?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	20f. (City or town) <u>N/A</u>	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1960</u> to <u>30 Sept 1960</u> , that (I) <u>(me)</u> last saw the deceased alive on <u>30 Sept 1960</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 29, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph C. Fitzgerald</u>				22d. ADDRESS <u>707 Camden Avenue Salisbury</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10852
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10851

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princes Anne</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Princess Anne Memorial Hospital</u>				d. STREET ADDRESS <u>Route 3 Box 63</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie</u> <u>White</u>				4. DATE OF DEATH Month Day Year <u>September 13 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cohored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>II/8/1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Samuel White</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Milbourne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mary L. Allen. Princes Anne, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriohypertensive C.V. disease</u> DUE TO (c) <u>Pneumonia</u> + (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>9-4-60</u> <u>3 yrs.</u> <u>9/5/60</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-4-1960</u> to <u>9-13-1960</u> , that (I) (we) last saw the deceased alive on <u>9-13-1960</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm B Smith</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9/13/60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/18/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City, town, or county) (State) <u>Deal Island</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr</u>				ADDRESS <u>Princess Anne, Md</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Friend</u>	

10852 - CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND STATISTICS
ST. PAUL, MINNESOTA

10852

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10853
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10852

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 424 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle James Last Willoughby		4. DATE OF DEATH Month Sept. Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsman - Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) M.D.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Willoughby		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Howard Willoughby, Cambridge, Md	
17. INFORMANT Howard Willoughby, Cambridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal cirrhosis of the liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 20 19 59 , to Sept. 16 , 19 60 , that (I) (we) last saw the deceased alive on Sept. 16 , 19 60 , and that death occurred at 3:45 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED 9/16/60	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 17	
23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION (City, town, or county) (State) East New Market Md	
24. FUNERAL DIRECTOR'S SIGNATURE H. H. Willoughby & Son		25a. REC'D BY REGISTRAR SEP 22 '60	
ADDRESS East New Market		25b. REGISTRAR'S SIGNATURE Arthur S. Knead	

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CERTIFICATE OF DEATH

10853

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last YOUNG			4. DATE OF DEATH Month Sept. Day 6 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1880	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William M. Insley			14. MOTHER'S MAIDEN NAME Katherine Denton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT James Insley, Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis - left.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 3, 1960 to Sept. 6, 1960 , that (I) (we) last saw the deceased alive on Sept. 6, 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.					
22a. SIGNATURE L. V. Maldve		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/6/60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-9-60	23c. NAME OF CEMETERY OR CREMATORY Birchview Cem.		23d. LOCATION (City, town, or county) (State) Birchview, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. H. Pearson		ADDRESS Birchview, Md.		25a. REC'D BY REGISTRAR DATE SEP 9 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



CERTIFICATE OF ANALYSIS

10422

U.S. DEPT. OF HEALTH
AND HUMAN SERVICES
BUREAU OF FOOD SAFETY
AND INSPECTION SERVICE

TO: *Mr. J. E. Smith*
FROM: *Mr. J. E. Smith*
SUBJECT: *Analysis of Food Sample*
DATE: *10/1/55*
ANALYST: *J. E. Smith*
FINDINGS: *Sample analyzed for... results...*
REMARKS: *...*